STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005164	A. BUILDING: _____ B. WING _____	03/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHSOUTH DEACONESS REHABILITATION HOSI	4100 COVERT AVE EVANSVILLE, IN 47714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a State hospital complaint survey. Dates: 3/6/2014 Facility Number: 005164 Complaint: IN00142850 Unsubstantiated: Lack of sufficient evidence. Surveyor: Albert Daeger, CFM, SFPIO Medical Surveyor Healthsouth Deaconess Rehabilitation Hospital was in compliance with 410 IAC 15-1.5-1, Dietetic services and 410 IAC 15-1.5-2, Infection control, Hospital Licensure Rules. QA: claughlin 03/21/14	S 000		